STATE OF CALIFORNIA--OFFICE OF ADMINISTRATIVE LAW

EMERGENCY

NOTICE PUBLICATION/REGULATIONS SUBMISSION (See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-09)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-		2009-1123-09E

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OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY
Managed Risk Medical Insurance Board

AGENCY FILE NUMBER (If any)
ER-2-09

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)
MRMIP Guaranteed Issue Pilot Program Reconciliation

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	ADOPT	
TITLE(S) 10	AMEND 2698.600 and 2698.602	
	REPEAL	

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☒ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify) _____
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective 30th day after filing with Secretary of State
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☒ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify)

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Dianne Knox	(916) 324-0592	(916) 445-0898	dknox@mrmib.ca.gov

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE	DATE
Randi Turner	11/23/09

TYPED NAME AND TITLE OF SIGNATORY
Randi Turner, Chief, Human Resources and Program Services

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STATE OF CALIFORNIA
MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814

TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.5 MAJOR RISK MEDICAL INSURANCE PROGRAM
AMEND SECTIONS 2698.600, 2698.602 AND 2698.604

Article 6. Pilot Program Payments

Text proposed to be added is displayed in underline type.
Text proposed to be deleted is displayed in ~~strikeout~~ type.

Section 2698.600 is amended to read:

2698.600. Semiannual Interim Payment and Reporting Procedures for Pilot Program Health Plans

(a) The semiannual interim payment process for Pilot Program payment shall occur starting at the end of the first reporting period, September 1, 2003 through December 31, 2003, and on June 30 and December 31 of each year thereafter, as long as there are Program Graduates or Program Graduate dependents enrolled. In order to qualify for a semiannual interim payment a Pilot Program health plan shall submit a semiannual interim enrollment report no later than 90 days after the semiannual reporting period as established above in this section. If a Pilot Program health plan does not submit a semiannual interim enrollment report by the end of the 90 day period, the plan will not receive an interim payment for that period.

(b) The semiannual interim enrollment report shall be submitted for each program graduate enrolled in the Pilot Program standard benefit plan during the semiannual interim period, and consist of:

(1) A signed certification that all program graduates for whom the Pilot Program health plan has made claim are enrolled in a Pilot Program standard benefit plan.

(2) The following information, to be submitted electronically, in a format specified by the Board, which consists of the following elements for each Program Graduate enrolled in the Pilot Program standard benefit plan during the semiannual interim period:

(A) The Program Graduate's unique identification number,

(B) The Pilot Program health plan's own identification number for the Program Graduate,

(C) The Program Graduate's full name,

(D) The Program Graduate's home address including house or unit number, street, city, county, state, and zip code,

(E) The name of each Program Graduate dependent who is covered under the Pilot Program at the same time as the program graduate,

(F) The date of birth of each Program Graduate and Program Graduate dependent,

(G) The Program Graduate's and any Program Graduate dependent's date of disenrollment from the Program, as indicated on the Certificate of Program Completion,

(H) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan,

(I) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan, when transferred from one Pilot Program health plan to another.

(J) The Program Graduate's and any Program Graduate dependent's date of disenrollment in the Pilot Program health plan, if disenrollment has occurred during the interim semiannual reporting period.

(3) The semiannual interim enrollment report shall include an estimate, adjusted for incurred but not reported (IBNR) costs, of the amount expended for program graduates and program graduate dependents, and the total amount of

premium payments received to the Pilot Program health plan during the reporting period.

(c) The Board will issue an interim payment no later then ~~60~~ 45 days after receipt of a valid semiannual interim payment report, consisting of all the elements as stated above in subsection (b). The payment will be determined using the following formula for each individual:

the most recent average premium as established by the Board during its semiannual determination of estimated enrollment times one half (the absolute value of the prior calendar year loss ratio minus 110 percent)

(d) The semiannual interim payment reporting process shall be subject to review and/or audit by the Board or its authorized representative in order to verify Program Graduates, and Program Graduate dependents, enrollment through a Pilot Program health plan in the Pilot Program standard benefit plan, for a period of four years after an interim payment has been made.

NOTE: Authority cited: Sections 1373.62, Health and Safety Code; 10127.15, 12711 and 12712, Insurance Code. Reference: Sections 1373.62 and 1373.622, Health and Safety Code; 10127.15, 12711 and 12712, Insurance Code.

Section 2698.602 is amended to read:

2698.602. Annual Reconciliation Reporting and Payment Process for Pilot Program Health Plans

(a) The time period for annual reconciliation, reports and payment shall be as follows:

(1) The annual reconciliation reporting and payment process shall start one year after the end of each reporting period established in Health and Safety Code Section 1373.62(g)(1) and Insurance Code 10127.15(g)(1). These periods are as follows:

September 1, 2003, to December 31, 2003, inclusive,
January 1, 2004, to December 31, 2004, inclusive,
January 1, 2005, to December 31, 2005, inclusive,
January 1, 2006, to December 31, 2006, inclusive,
January 1, 2007, to August 30, 2007, inclusive.

(2) However, for the purpose of reconciliation and payment, the January 1, 2007 to August 30, 2007 reporting period shall be extended through December 31, 2007, and shall include Program Graduates and Program Graduate dependents that remain enrolled in a Pilot Program health plan's standard benefit plan on September 1, 2007 (the day the Pilot Program becomes inoperative). Pilot Program health plans with such program graduates or program graduate dependents may continue to report, and be eligible for reconciliation and payment, one year after the close of each calendar year until the plan no longer has any remaining program graduates or program graduate dependents.

(b) In order to qualify for annual reconciliations, a Pilot Program health plan shall submit an annual report for each calendar year by December 31 of ~~each~~ the following year, starting ~~in~~ with a December 31, 2004 due date for calendar year 2003.

(1) For reconciliations addressing calendar years 2003 through 2007 inclusive, Pilot Program health plans ~~who~~ that submit these reports by the ~~established~~ December 31 due ~~dates~~ date will be given priority for reconciliation and any resulting payments. Pilot Program health plans ~~who~~ that submit reports after the established due dates will be reconciled, and any resulting payments made from available funds, in order of the day of receipt of the report.

(2) For reconciliations addressing calendar year 2008 and all subsequent calendar years, a Pilot Program health plan that submits the required report after the December 31 due date shall not be entitled to be paid any amount pursuant to this section for the applicable calendar year and shall refund to the board, within thirty-five days of notification by the board, any amount previously paid to the plan for the applicable calendar year pursuant to section 2698.600.

(c) The annual report to be submitted by Pilot Program health plans shall consist of three parts:

(1) For a Program Graduate and a Program Graduate dependent enrolled in a Pilot Program standard benefit plan, an enrollment and program report to be submitted electronically, in a format to be specified by the Board, for the reporting periods established above in subsection (a)(1) and (2):

(A) The Program Graduate's unique identification number,

(B) The Pilot Program health plan's own identification number for the Program Graduate,

(C) The Program Graduate's full name,

(D) The Program Graduate's home address including house or unit number, street, city, county, state and zip code,

(E) The name of each Program Graduate dependent who is covered under the Pilot Program at the same time as the Program Graduate,

(F) The date of birth of each Program Graduate and Program Graduate dependent,

(G) The Program Graduate's and any Program Graduate dependent's date of disenrollment from the Program, as indicated on the Certificate of Program Completion,

(H) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan,

(I) The Program Graduate's and any Program Graduate dependent's date of enrollment in the Pilot Program health plan, when transferred from one Pilot Program health plan to another.

(J) The Program Graduate's and any Program Graduate dependent's date of disenrollment in the Pilot Program health plan, if disenrollment has occurred during the annual reporting period, and if disenrollment was the result of any of the following:

1. Program Graduate's request;
2. eligibility for Medicare Part A and Part B;
3. eligibility for other health insurance;
4. non-payment of premiums;
5. fraud;

6. death; or
7. other.

(K) Dollar amount of all premiums paid by, or on behalf of each Program Graduate, and Program Graduate dependent for coverage in the Pilot Program standard benefit plan during the reporting period.

(2) A claims report, to be provided electronically for each program graduate and program graduate dependent enrolled with the Pilot Program health plan for service provided and expense payments made during the annual reporting period. The reporting expense payments shall be limited to expense payments made to providers of services and shall not include the Pilot Program health plan administrative expenses, and shall not include incurred but not reported costs. The report, entitled "Major Risk Medical Insurance Pilot Program Health Plan and Claims Reporting File Layout and Field Description," dated September, 2003 is hereby incorporated by reference.

(3) A signed certification that all program graduates for whom the Pilot Program health plan has made claim are enrolled in a Pilot Program standard benefit plan.

(4) An incomplete report shall be returned with an explanation to the Pilot Program health plan of the reasons for incompleteness.

(d) The Board will review and reconcile each annual complete report within 120 days of receipt to the Pilot Program health plan of the findings based on the following formula:

one half (aggregate claims plus aggregate standard monthly administrative fee minus aggregate premiums) ~~plus aggregate standard monthly administrative fee~~ minus semiannual interim payments paid for that reporting period equals Final Payment.

In order to determine an aggregate monthly administrative fee for individuals in the Pilot Program, the Board will use a weighted average, weighted by plan population and adjusted by a factor of the number of dependents in the Program, of the current administrative fees for plans participating in the Program.

(1) The Board may make adjustments in determining the final payment to any Pilot Program health plan as follows:

(A) to delete any payments for persons who cannot be determined to be a Program Graduate or Program Graduate dependent during the reporting period,

(B) to delete expenses for services beyond the date of disenrollment during a reporting period for a Program Graduate or Program Graduate dependent,

(C) to delete expenses for services for the Program Graduate or Program Graduate dependent beyond the date of eligibility for Medicare Part A and Medicare Part B, and who are not in Medicare solely because of end stage renal disease,

(D) to delete expenses that occurred for services outside of the reporting period, and

(E) to delete all expenses beyond the $200,000 annual and $750,000 lifetime benefit limits for each individual in a Pilot Program standard benefit plan.

(2) If the current reconciliation indicates that further payment is owed to the Pilot Program health plan, the payment shall be made 30 days after notification of the reconciliation results. If the annual reconciliation indicates that an overpayment has been made through the semiannual interim payment process, the Pilot Program health plan shall pay the overpayment to the Board within 35 days after the notification of reconciliation.

(e) The annual reconciliation, reporting and payment process shall be subject to review and/or audit by the Board or its authorized representatives, for a period of four years after a reconciliation payment by either the Board or a Pilot Program health plan has been made.

NOTE: Authority cited: Sections 1373.62, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code. Reference: Sections 1373.62 and 1373.622, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code.

MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814

FINDING OF EMERGENCY
ER-2-09
Guaranteed Issue Pilot Program Reconciliation

FINDING OF EMERGENCY

Pursuant to Section 11346.1 of the Government Code, the Managed Risk Medical Insurance Board (MRMIB) found at its July 30, 2009, meeting, that an emergency exists and that the immediate adoption of the attached proposed regulations is necessary to avoid serious harm to the public peace, health and safety, or general welfare. A copy of the Finding of Emergency adopted by the Board is attached.

SPECIFIC FACTS DEMONSTRATING THE NEED FOR IMMEDIATE ACTION

In 2002, the Legislature passed and the Governor signed AB 1401 (Chapter 794, Statutes of 2002). AB 1401 created a four-year pilot (the Guaranteed Issue Pilot Program, or GIP) intended to bring additional funds into the Major Risk Medical Insurance Program (MRMIP). In MRMIP, the state bears most or all of the losses for health care not covered by subscriber premiums. Pursuant to AB 1401, MRMIB was required to disenroll MRMIP subscribers after 36 consecutive months. (Insurance Code sec. 12725(f).) Disenrolled individuals instead had access to coverage in the private market: Every individual market health care service plan and health insurer was required to sell them a "standard benefit plan" that paralleled MRMIP coverage with a slightly higher annual benefit limit. GIP premiums were, by law, 110% of MRMIP premiums.

The GIP pilot brought additional funds into MRMIP because, pursuant to the statute, MRMIB and GIP plans split the aggregate losses equally rather than having MRMIB bear most of the losses as it does in MRMIP. (Health & Safety Code sec. 1373.62 and Insurance Code sec. 10127.5, as enacted in Chapter 794, Statutes of 2002, and amended by Chapter 683, Statutes of 2006.) The statutory requirement that MRMIP disenroll subscribers after 36 months expired January 1, 2008. The statutory provision requiring guaranteed issue of GIP products and related provisions on the division of costs between GIP plans and MRMIP were repealed as of January 1, 2008. (See Health & Safety Code sec. 1373.62(j) and Insurance Code sec. 10127.5(j), now repealed.) However, plans must continue covering existing GIP subscribers and the rules concerning plan

reconciliations and division of costs continue to apply. (See, e.g., Health & Safety Code sec. 1372.622, and Insurance Code sec. 10127.16.)

The GIP statute provided for an annual, calendar-year-based reconciliation of health plans' GIP expenditures according to a formula. The statutory formula required MRMIB to pay GIP plans one half of their aggregate calendar year "*health care services*" expenditures not covered by premiums (Health & Safety Code sec. 1373.62(h)(1) and Insurance Code sec. 10127.5(h)(1).) The term "*health care services*" in turn was defined to mean plans' expenditures for health claims *plus* a monthly administrative fee equal to the average monthly administrative fee paid to plans in MRMIP. (Health & Safety Code sec. 1373.62(g)(2) and Insurance Code sec. 10127.5(g)(2).)

The statute, therefore, required that, through the GIP reconciliation process, MRMIB annually would pay plans one half of the following amount: aggregate annual health claims *plus* monthly administrative fee *minus* aggregate premiums. However, through an error, the MRMIB regulations implementing the GIP pilot provided that MRMIB would pay GIP plans the following: (1) one half the difference between aggregate health claims paid and premiums *and* (2) the *full* monthly administrative fee. The difference between the two formulas is that the statutory formula in essence pays the GIP plans *one-half* the MRMIP monthly administrative fee whereas the formula in the regulations pays GIP plans the *full* administrative fee.

In 2008 through 2009, based on reconciliation data submitted by the GIP health plans in arrears, MRMIB completed the first round of annual reconciliations, for Calendar Years 2003 through 2006, with these plans. In the course of conducting these reconciliations, MRMIB discovered the error, described above, in the regulations. For the largest GIP health plan, this represents a difference of approximately $1.8 million for the 2003-2006 calendar years. The GIP plan reconciliations are conducted in arrears on an annual basis and will continue into the future. The next plan filings related to annual reconciliations will be due December 31, 2009. Because of the clear and unambiguous conflict between the GIP statute and the GIP regulations, the statute governs. However, because of the amounts involved, the importance of these funds at time of the State's budget shortfalls, and the impact on future year expenditures, MRMIB is promulgating emergency regulations to ensure that the regulations conform to the statute. The proposed emergency regulation also corrects two additional discrepancies between the statute and the regulations.

AUTHORITY AND REFERENCE CITATIONS

Authority: Section 1373.62, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code.

Reference: Sections 1373.62 and 1373.622, Health and Safety Code; and Sections 10127.15, 12711 and 12712, Insurance Code.

INFORMATIVE DIGEST AND POLICY STATEMENT OVERVIEW

Existing Law: Insurance Code Section 12700, et seq., established the Major Risk Medical Insurance Program (MRMIP) in 1991, under the direction of the Managed Risk Medical Insurance Board (MRMIB).

Title 10, California Code of Regulations, Chapter 5.5, implements the Major Risk Medical Insurance Program.

A summary of the proposed regulations' effect on existing law and regulations is as follows:

2698.600(c)

The statute required MRMIB to make interim payments to a GIP plan by 45 days following receipt of a plan's enrollment reports. (Health & Safety Code sec. 1373.62(h)(2), Insurance Code sec. 10127.15(h)(2).) The current regulations state that MRMIB shall make an interim payment no later then 60 days after receipt of a valid semiannual interim payment report. The proposed amendment changes "60 days" to "45 days" to reflect the language of the statute.

2698.602(b)

The statute requires GIP plans to submit their annual reconciliation reports within 12 months of the final date of the reporting period, i.e., December 31 of the year following the reporting year. (Health & Safety Code sec. 1373.62(g)(1), Insurance Code sec. 10127.15(g)(1).) The current regulations give "priority" to GIP plans submitting their annual reconciliation reports by December 31 of the year following the reporting year but allow for the possibility of late submissions to the extent that there are available funds. For annual reconciliation reports addressing 2008 (the first year for which plans' reconciliation reports are not yet due) and each subsequent calendar year, the proposed amendment clarifies that plans must submit reconciliation reports by December 31 of the year following the reporting year, as required in the statute.

2698.602(d)

As stated above, the statute requires MRMIB to reimburse GIP plans *one-half* of aggregate health care expenditures, *including the monthly administrative fee*, not covered by subscriber premiums, whereas the regulation requires MRMIB to

reimburse GIP plans one-half of aggregate health claims not covered by subscriber premiums plus the *full* administrative fee. The proposed amendment conforms the language of the regulation to the statute.

TECHNICAL, THEORETICAL, AND EMPIRICAL STUDY or REPORT DETERMINATIONS

The Proposed Substantial differentiation from existing comparable Federal Regulation or Statute: No.

Mandates on Local Agencies or School Districts: None.

Mandate Requires State Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None.

Costs to Any Local Agency or School District that Requires Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None.

Non-discretionary Costs or Savings Imposed on Local Agencies: None.

Costs or Savings to Any State Agency: Unknown. The proposed regulation would conform the regulations to the statute and ensure that the state not incur unnecessary dispute-related costs at a time of state budget shortfalls.

Costs or Savings in Federal Funding to the State: Unknown. The proposed regulation would conform the regulations to the statute and ensure that the state not incur unnecessary dispute-related costs at a time of state budget shortfalls.